BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **FERNANDO CRUZADO, M.D.** License No. 30961 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-05-0652A **CONSENT AGREEMENT FOR LETTER OF REPRIMAND AND PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Fernando Cruzado, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any

waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

12. Respondent has read and understands the condition(s) of probation.

FERNANDO CRUZADO, M.D. DATED: 5/2/07

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 30961 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0652A after receiving a complaint regarding Respondent's care and treatment of a twenty-five year-old female patient ("CR").

4. On March 26, 2004 CR presented to Respondent with a rash on the right side of her mid-thoracic back. CR complained the rash itched and was painful causing her to feel nauseated and had started after she used a tanning bed one week prior. Respondent examined CR and documented she had no history of systemic illness. Respondent's examination revealed a maculopapular rash that was tender to touch and erythematous (redness of the skin). Respondent's assessment was dermatitis and he ruled out a fungal infection. Respondent biopsied the lesion on CR's back and injected the area with "Lidocaine/Marcaine/Kenalog." There is no documentation in record of the dose of Kenalog. Respondent provided CR with Mycolog II AAA prescription to be used three times per day, counseled CR regarding sun protection, and suggested she come back in one week for follow up.

5. On April 6, 2004 CR returned for a follow up visit. The rash had disappeared and she only had some itching around the area biopsied. The biopsy revealed findings consistent with early discoid lupus. Respondent oriented CR about the "diagnosis, management and treatment options and complications of conditions and secondary effects of treatment." Respondent provided CR with Disprosone 0.052 to apply on the affected area twice per day.

6. On October 29, 2004 CR returned complaining of a rash on her back. Respondent examined the area and documented a midscapular discoid whitish lesion with erythematous borders. Respondent's assessment was exacerbation of discoid lupus. The concentration of triamcinolone (Kenalog) to be used by a physician is 3mg/ml. Respondent adminstered an intralesional injection of 40 mg of Kenalog, an excessive dose, Xylocaine and Marcaine 0.25 and "oriented [CR] to get a dermatology and rheumatology referral."

7. On January 6, 2005 CR consulted her rheumatologist ("Rheumatologist") regarding Respondent's assessment of discoid lupus. Rheumatologist noted CR had a subcutaneous depression from steroid injections measuring 3 x 3 cm and assessed a steroid injection complication with subcutaneous atrophy. Rheumatologist ordered CR's medical records from Respondent and received them on January 24, 2005.

8. On March 1, 2005 Rheumatologist referred CR to a plastic surgeon ("Plastic Surgeon"). Plastic Surgeon examined CR and also assessed she had steroid atrophy. Plastic Surgeon excised the atrophic area with good results, but left a three inch scar right of the midline. The pathology report was read as epidermal and dermal atrophy and "in the appropriate clinical setting, these changes would be consistent with corticosteroid atrophy."

9. Board Staff requested Respondent provide a copy of CR's medical records. Board Staff also requested CR and Rheumatologist provide medical records in their possession. The copies of CR's medical records received from Rheumatologist appear to be the same copies provided to the Board by CR; however, they are different than the copies Respondent provided to the Board. Specifically, in the records provided by Respondent on page 3 is the office visit for March 26, 2004 containing the comment "(Pt. oriented about biopsy & tx – Agrees c/tx)." This comment is not on page 3 of the records Rheumatologist received on January 24, 2005, but is located on page 17. This comment is

also not on page 3 of CR's copy of the medical record, but instead it is on page 5. Additionally, page 1 of Respondent's records for the office visit for October 29, 2004 states he "[o]riented about IL inj. Review dx & management of disease." This comment does not appear until page 18 of the records Rheumatologist received and is located on page 5 of CR's copy. These inconsistencies indicate Respondent added information to the record after Rheumatologist requested a copy.

10. The standard of care requires at the initial office visit a physician to treat discoid lupus with topical steroids. The standard of care requires a physician to discuss the risks and benefits of procedures including intralesional corticosteroid injections.

11. Respondent deviated from the accepted standard of care because at CR's initial office visit he did not treat CR's discoid lupus with topical steroids. Rather, he treated her with an intralesional corticosteroid injection and at a subsequent office visits he treated her with a topical steroid cream and an excessive dose of an intralesional corticosteroid injection. Respondent deviated from the standard of care because he did not discuss the risks, such as cutaneous atrophy or dyspigmentation, with CR prior to administering the intralesional corticosteroid injections.

12. CR developed fat pad necrosis and atrophy and, if CR had fungal dermatitis, topical and intralesional steroids would have worsened the infection.

13. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he failed

to document in CR's medical record the dosage of Kenalog administered at the March 26, 2004 office visit.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); A.R.S. § 32-1401(27)(t) ("[k]nowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine..."); and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of a patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for failure to appropriately diagnose and treat discoid lupus, for altering medical records and for failure to maintain adequate medical records.

2. Respondent is placed on probation for one year with the following terms and conditions:

A. Continuing Medical Education

Respondent shall within **one year** of the effective date of this Order obtain **twenty hours** of Board Staff pre-approved Category I Continuing Medical Education (CME) in **record keeping** and **twenty hours** of Board Staff pre-approved Category I CME in **ethics**. Respondent must provide Board Staff with satisfactory proof of attendance. The CME

hours shall be in addition to the hours required for the biennial renewal of medical license. The probation shall terminate upon successful completion of CME hours.

B. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court order criminal probation, payments and other orders.

C. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

3. This Order is the final disposition of case number MD-05-0652A.

DATED AND EFFECTIVE this 8th day of June, 2007.

(SEAL)

ARIZONA MEDICAL BOARD

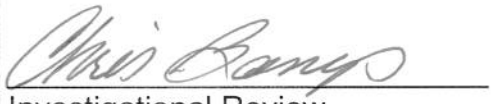
By _____
TIMOTHY C.MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 8th day of June, 2007 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 8th day of June, 2007 to:

Fernando Cruzado, M.D.
Address of Record



Investigational Review